CENTRAL OBSTETRICS & GYNECOLOGY

7141 Moon Road, Suite B ~ Columbus, GA 31909

MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

DATE OF BIRTH: __________ DATE LAST PHYSICAL EXAM: __________ BY WHOM? ______________

List any medications you currently take (prescription and over-the counter)

____

____

Please describe any health problem that you are having at this time

____

____

Do you have allergies to any medications? YES NO

If YES, list the medications: ______________________________

MENSTRAL HISTORY:

What is the date of your last menstrual period ___/___/___

Hold old were you when you started seeing your period? _____

How many days does your period flow (duration)______________

Do you have regualar periods? Yes No (circle one)

OBSTETRIC HISTORY:

Total Number of Preganancies: ____ Number of Miscarriages: ____

Number of Living Children: ____ Number of Abortions: ____

Number of Premature deliveries: _____

YEAR & TYPE OF DELIVERY ***Vaginal = V Cesarean = C***

Year _____ Type_____ Year _____ Type_____

Year _____ Type_____ Year _____ Type_____

Year _____ Type_____ Year _____ Type_____

List all major systemic illnesses:	YES	NO	UNKNOWN	DETAILS
Lung Disease/Asthma				
Seasonal Allergies				
Kidney Stones/UTI				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Headaches				
Gout				
Skin Disease				
Gastrointestinal Disease				
Blood Disorders				
Multiple Sclerosis				
Pelvic inflammatory disease				

List female surgeries: (hysterectomy, tubal ligation, breast augmentation with dates): ______________

List any other surgeries you have had (appendectomy, heart surgery. etc.): ______________

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (blurred vision, glare, redness, pain, tearing, burning, itching, etc.)			
GENERAL/CONSTITUTIONAL (fever, weight loss. weight gain, fatigue, cancer)			
EARS, NOSE, THROAT (stuffy nose, ear ache, dry mouth, etc.)			
CARDIOVASCULAR (high BP, congestive heart failure, chest pain, heart attack, carotid disease, irregular heart beat, etc.)			
RESPIRATORY (wheezing, asthma, emphysema, coughing, bronchitis, TB, shortness of breath, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, ulcerative colitis, Crohn's, diarrhea, etc.)			
FEMALES: Are you pregnant? Nursing?			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, kidney stones, kidney failure, etc.)			

	YES	NO	DETAILS
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, osteoarthritis, rheumatoid arthritis, fibromyalgia, gout, etc.)			
SKIN (pimples, warts, growths, rash, eczema, seborrhea, psoriasis, etc.)			
NEUROLOGICAL (numbness, headache, stroke, seizures, multiple sclerosis, myasthenia gravis, migraines, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, claustrophobia, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
BLOOD/LYMPH (bleeding problems, anemia, sickle cell, high cholesterol, thalassemia, HIV/AIDS, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, seasonal allergies, etc.)			

FAMILY HISTORY: *(Mother, Father, Grandparent, Sibling)* Has any member of your family had these diseases?

	YES	NO	UNKNOWN	DETAILS
Ovarian Cancer				
Breast Cancer				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer (other types)				
Thyroid Disease				
Arthritis				
Macular Degeneration				
Multiple Sclerosis				
Other (Explain)				

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Type of Employment: ______________________________

Do you live alone? Yes or No
If YES, is there someone who can help you? Name: ______________________ Phone: ______________

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? Yes NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? Yes NO If YES: occasional ½ pack/day 1 pack/day 1+ pack/day
How many years? ______________ *When did you quit?* ______________

Date of last Pap Smear: ______________________ ❑ Normal ❑ Abnormal

Date of last Mammogram: ______________________ ❑ Normal ❑ Abnormal

Date of last Colonoscopy if 50 years or above: ______________________ ❑ Normal ❑ Abnormal

FAMILY DOCTOR: ______________________________

HOW WERE YOU REFERRED? Family Doctor Yellow Pages Friend Newspaper

Other (explain) ______________________________

Signature: ______________________________ Date: ______________

Reviewed by Doctor: ______________________________ Date: ______________

Patient Name: ______________________________________ Date: _______________

[ ] I give permission to Columbus Women's Care to notify __________________________ of my blood work/test results and other personal health information.

[ ] I give permission to Columbus Women's Care to leave the results of my blood work/test results on my answering machine.

[ ] I give permission to Columbus Women's Care to obtain test results from other doctor's offices and hospitals pertinent to my care.

X _________________________________

Patient Signature

X _________________________________

Witness Signature

Notice of HIPPA Privacy Policy Acknowledgement of Receipt

X _________________________________

X _________________________________

Patient Signature Witness

PRINT
NAME _____________________________________ DATE _______________________